

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: () _____
 (Last, First, M.I.)
 Address: _____ City: _____ County: _____ State: _____ Zip: _____
 Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

– Patient identifier information is not transmitted to CDC! –

U.S. DEPARTMENT OF HEALTH
 & HUMAN SERVICES
 Centers for Disease Control
 and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

II. HEALTH DEPARTMENT USE ONLY
DATE FORM COMPLETED:

Mo. Day Yr.
 [] [] [] [] [] [] [] [] [] [] [] []

REPORT SOURCE:

[] []

SOUNDEX CODE:

[] [] [] []

REPORT STATUS:

1 New Report
 2 Update

REPORTING HEALTH DEPARTMENT:

State: _____
 City/County: _____

State Patient No.:

[] [] [] [] [] [] [] [] [] [] [] []

City/County Patient No.:

[] [] [] [] [] [] [] [] [] [] [] []

III. DEMOGRAPHIC INFORMATION
DIAGNOSTIC STATUS AT REPORT (check one):

1 HIV Infection (not AIDS)
 2 AIDS

AGE AT DIAGNOSIS:

[] [] Years
 [] [] Years

DATE OF BIRTH:

Mo. Day Yr.
 [] [] [] [] [] [] [] [] [] [] [] []

CURRENT STATUS:

Alive Dead Unk.
 1 2 9

DATE OF DEATH:

Mo. Day Yr.
 [] [] [] [] [] [] [] [] [] [] [] []

STATE/TERRITORY OF DEATH:

SEX:

1 Male
 2 Female

ETHNICITY: (select one)

1 Hispanic 9 Unk
 2 Not Hispanic or Latino

RACE: (select one or more)

☐ American Indian/Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unk

COUNTRY OF BIRTH:

1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico)
 (specify): _____
 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS:

City: _____ County: _____ State/Country: _____ Zip Code: [] [] [] [] [] [] [] [] [] [] [] []

IV. FACILITY OF DIAGNOSIS

Facility Name _____

City _____

State/Country _____

FACILITY SETTING (check one)

1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one)

01 Physician, HMO 31 Hospital, Inpatient
 88 Other (specify): _____

OTHER ETHNICITY:

Does the patient consider him / herself Arabic?
 Yes No Unknown (Circle your answer)

V. PATIENT HISTORY
AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify 1 Factor VIII 2 Factor IX 8 Other disorder: (Hemophilia A) (Hemophilia B) (specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. Yr. Last Mo. Yr. First [] [] [] [] Last [] [] [] []			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

VI. LABORATORY DATA
1. HIV ANTIBODY TESTS AT DIAGNOSIS:

(Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE
					Mo. Yr.
• HIV-1 EIA	1	0	–	9	[] [] [] []
• HIV-1/HIV-2 combination EIA	1	0	–	9	[] [] [] []
• HIV-1 Western blot/IFA	1	0	8	9	[] [] [] []
• Other HIV antibody test (specify): _____	1	0	8	9	[] [] [] []

2. POSITIVE HIV DETECTION TEST: (Record earliest test)

☐ culture ☐ antigen ☐ PCR, DNA or RNA probe
 • Other (specify): _____

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* COPIES/ML Mo. Yr.
 [] [] [] [] [] [] [] [] [] [] [] []

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

4. Date of last documented negative HIV test

(specify type): _____ Mo. Yr. [] [] [] []

5. If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?

Yes No Unk.
 1 0 9

If yes, provide date of documentation by physician

Mo. Yr. [] [] [] []

4. IMMUNOLOGIC LAB TESTS:
AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

• CD4 Count	[] [] [] []	cells/μL	Mo. Yr. [] [] [] []
• CD4 Percent	[] []	%	[] [] [] []
First <200 μL or <14%	[] [] [] []	cells/μL	Mo. Yr. [] [] [] []
• CD4 Count	[] [] [] []	cells/μL	[] [] [] []
• CD4 Percent	[] []	%	[] [] [] []

VII. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: () _____ Medical Record No. _____
 (Last, First, M.I.)
 Hospital/Facility: _____ Person Completing Form: _____ Phone No.: () _____
– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes <input type="checkbox"/> No <input type="checkbox"/>	ENTER DATE PATIENT WAS DIAGNOSED AS:	Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Symptomatic (not AIDS):
		Mo. Yr. <input type="text"/> <input type="text"/>	Mo. Yr. <input type="text"/> <input type="text"/>

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Pres.	Initial Date Mo.	Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Pres.	Initial Date Mo.	Yr.
Candidiasis, bronchi, trachea, or lungs	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Lymphoma, Burkitt's (or equivalent term)	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>
Candidiasis, esophageal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Lymphoma, immunoblastic (or equivalent term)	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>
Carcinoma, invasive cervical	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Lymphoma, primary in brain	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>
Coccidioidomycosis, disseminated or extrapulmonary	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	<i>Mycobacterium avium</i> complex or <i>M.kansasii</i> , disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Cryptococcosis, extrapulmonary	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	<i>M. tuberculosis</i> , pulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	<i>M. tuberculosis</i> , disseminated or extrapulmonary*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Cytomegalovirus disease (other than in liver, spleen, or nodes)	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	<i>Mycobacterium</i> , of other species or unidentified species, disseminated or extrapulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Cytomegalovirus retinitis (with loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<i>Pneumocystis carinii</i> pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
HIV encephalopathy	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Pneumonia, recurrent, in 12 mo. period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Progressive multifocal leukoencephalopathy	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>
Histoplasmosis, disseminated or extrapulmonary	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Salmonella septicemia, recurrent	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>
Isosporiasis, chronic intestinal (>1 mo. duration)	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>	Toxoplasmosis of brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Kaposi's sarcoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Wasting syndrome due to HIV	<input type="checkbox"/>	NA	<input type="text"/>	<input type="text"/>

Def. = definitive diagnosis Pres. = presumptive diagnosis * RVCT CASE NO.:

• If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ☐ Yes ☐ No ☐ Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <small>MI law requires physician to notify known partners or requests help from local health departments.</small> This patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health department <input type="checkbox"/> Physician/provider	This patient is receiving or has been referred for: • HIV related medical services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unk. • Substance abuse treatment services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unk.
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This patient received or is receiving: • Anti-retroviral therapy Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> • PCP prophylaxis Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/>	This patient has been enrolled at: Clinical Trial <input type="checkbox"/> NIH-sponsored <input type="checkbox"/> HRSA-sponsored <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown	This patient's medical treatment is primarily reimbursed by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private insurance/HMO <input type="checkbox"/> No coverage <input type="checkbox"/> Other Public Funding <input type="checkbox"/> Clinical trial/government program <input type="checkbox"/> Unknown
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FOR WOMEN: • This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown
 • Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown
 • Has this patient delivered live-born infants? ☐ Yes (if delivered after 1977, provide birth information below for the most recent birth) ☐ No ☐ Unknown

CHILD'S DATE OF BIRTH: Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	Hospital of Birth: _____ City: _____ State: _____	Child's Surname: <input type="text"/>	Child's State Patient No. <input type="text"/>
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X. COMMENTS: